






Assistance Application

Michigan Department of Human Services (DHS)

Application Instructions

- If you answer **ALL** the questions on the Assistance Application, we can see if you are eligible for all programs. **PLEASE PRINT** your answers.
- Check the programs you are applying for.** The program symbols below can be seen in all the headings in the application. These symbols help you decide questions you **MUST** answer for the program(s) you are applying for. For more information about programs, see the **Information Booklet**.
 - ☐  Food Assistance Program (FAP)
 - ☐  Medical Assistance (MA) (doctor bills, hospital bills, prescriptions, Medicare premiums)
 - ☐  Child Development and Care (CDC) (child care payments)
 - ☐  Cash Assistance for low-income families with children, Refugee Assistance (FIP, RAP)
Cash Assistance for low-income disabled adults (SDA)
 - ☐  State Emergency Relief (SER) (utility shut-off, eviction notice, burial or other non-food emergency)
Note: You must complete both the Assistance Application and Supplemental Application for SER.
- If you cannot complete this application now, you may complete the Filing Form in the **Information Booklet** or online at www.michigan.gov/dhs-forms. Return the Filing Form to the local office to protect your application date. DHS will still need to receive your completed Assistance Application before any benefits can be approved.

If you need help filling out this application, please contact the DHS office in your area. If they refuse, you may call (517) 373-0707.

1. If you need help because of disability or language, what kind of help do you need?

☐ Interpreter ☐ Sign Language ☐ Other (wheelchair, etc.) _____

2. If you do not speak English, what language do you speak? _____

Si usted necesita ayuda llenando esta solicitud, por favor póngase en contacto con la oficina DHS en su área. Si ellos se niegan, usted puede llamar (517) 373-0707.

1. ¿Si usted necesita ayuda debido de incapacidad o idioma, qué tipo de ayuda necesita usted?

☐ Intérprete ☐ Dactilología ☐ Otro (silla de ruedas, etc.) _____

2. ¿Si usted no habla inglés, qué idioma habla? _____

.....
إن كنت تتطلب مساعدة في ملء هذا الطلب، فيرجى الاتصال بمكتب DHS في المنطقة التي تعيش فيها. إذا رفضوا مساعدتك، فيمكنك الاتصال بالرقم ٣٧٣-٠٧٠٧ (٥١٧).

١. إن كنت تتطلب مساعدة لأنك تعاني من إعاقة وعجز أو صعوبة في فهم اللغة، فما نوع المساعدة التي تحتاجها؟

_____ ☐ مترجم شفهي ☐ لغة إشارة ☐ غير ذلك (كرسي مدولب، ... إلخ)

٢. إن كنت لا تتكلم اللغة الإنجليزية، فما هي اللغة التي تتكلمها؟ _____

Date Application Received in Local Office

For Office Use Only

Grantee Name

Grantee Client ID

Case Number

County

District

Section

Unit

Specialist

State of Michigan Voter Registration Application

and Michigan Driver License/Personal Identification Card Address Change Form

If you are not registered to vote where you live now, would you like to register to vote here today?

☐ Yes ☐ No

Applying or declining to register to vote will not effect the amount of help that you will be provided by this department. If you do not check either box, you will be considered to have decided not to register to vote at this time.

If you would like help filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the voter registration application form in private.



A. Information About You and Your Household

NOTE: Ask for Additional Household Information pages if needed.

- List all persons in your household (everyone living in your home) even if they are not there all the time and you are not applying for them.
- If you are filling the application out for a patient in a nursing home, list the patient first, then the patient's spouse and any dependents at home.

Answer for Everyone in Your Household (list YOURSELF first)

Name (last, first, middle initial)		Date of Birth	SELF
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Is this person a <input type="checkbox"/> migrant or <input type="checkbox"/> seasonal farmworker?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship to You
Marital Status	Race (optional)	What kind of help does this person need?	
<input type="checkbox"/> Married <input type="checkbox"/> Never Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	<input type="checkbox"/> White (non-hispanic) <input type="checkbox"/> Black <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Hispanic <input type="checkbox"/> American Indian/Alaska Native What Tribe? _____	<input type="checkbox"/> Food <input type="checkbox"/> Medical <input type="checkbox"/> Child Care <input type="checkbox"/> Cash for Families or Disabled Adults <input type="checkbox"/> State Emergency Relief <input type="checkbox"/> None	
Highest grade finished in school _____			
Are you in school? (school, college or university) <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, ► Name of School _____ <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time			
Answer if You Want Help			
U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____-_____-_____ Social Security Number		
* Optional if applying ONLY for child care or emergency medical services.			

Answer for Person 2

Name (last, first, middle initial)		Date of Birth	Relationship to You
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Is this person a <input type="checkbox"/> migrant or <input type="checkbox"/> seasonal farmworker?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship to You
Marital Status	Race (optional)	What kind of help does this person need?	
<input type="checkbox"/> Married <input type="checkbox"/> Never Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	<input type="checkbox"/> White (non-hispanic) <input type="checkbox"/> Black <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Hispanic <input type="checkbox"/> American Indian/Alaska Native What Tribe? _____	<input type="checkbox"/> Food <input type="checkbox"/> Medical <input type="checkbox"/> Child Care <input type="checkbox"/> Cash for Families or Disabled Adults <input type="checkbox"/> State Emergency Relief <input type="checkbox"/> None	
Highest grade finished in school _____			
Is Person 2 in school? (school, college or university) <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, ► Name of School _____ <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time			
Answer if Person 2 Wants Help			
U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____-_____-_____ Social Security Number		
* Optional if applying ONLY for child care or emergency medical services.			

A. Information About You and Your Household (continued)

NOTE: Ask for Additional Household Information pages if needed.

**Answer for Person 3**

Name (last, first, middle initial) _____ Date of Birth _____ Relationship to You _____

Gender ☐ Male ☐ Female Is this person a ☐ migrant or ☐ seasonal farmworker? ☐ Yes ☐ No

Marital Status **Race (optional)** **What kind of help does this person need?**

☐ Married ☐ White (non-hispanic) ☐ Food
☐ Never Married ☐ Black ☐ Medical
☐ Divorced ☐ Asian/Pacific Islander ☐ Child Care
☐ Separated ☐ Hispanic ☐ Cash for Families or Disabled Adults
☐ Widowed ☐ American Indian/Alaska Native ☐ State Emergency Relief
What Tribe? _____ ☐ None

Highest grade finished in school _____

Is Person 3 in school? (school, college or university) ☐ Yes ☐ No

If yes, ▶ Name of School _____ ☐ Full Time ☐ Part Time

Answer if Person 3 Wants Help

U.S. Citizen? ☐ Yes ☐ No Social Security Number _____ * Optional if applying ONLY for child care or emergency medical services.

Answer for Person 4

Name (last, first, middle initial) _____ Date of Birth _____ Relationship to You _____

Gender ☐ Male ☐ Female Is this person a ☐ migrant or ☐ seasonal farmworker? ☐ Yes ☐ No

Marital Status **Race (optional)** **What kind of help does this person need?**

☐ Married ☐ White (non-hispanic) ☐ Food
☐ Never Married ☐ Black ☐ Medical
☐ Divorced ☐ Asian/Pacific Islander ☐ Child Care
☐ Separated ☐ Hispanic ☐ Cash for Families or Disabled Adults
☐ Widowed ☐ American Indian/Alaska Native ☐ State Emergency Relief
What Tribe? _____ ☐ None

Highest grade finished in school _____

Is Person 4 in school? (school, college or university) ☐ Yes ☐ No

If yes, ▶ Name of School _____ ☐ Full Time ☐ Part Time

Answer if Person 4 Wants Help

U.S. Citizen? ☐ Yes ☐ No Social Security Number _____ * Optional if applying ONLY for child care or emergency medical services.

Answer for Person 5

Name (last, first, middle initial) _____ Date of Birth _____ Relationship to You _____

Gender ☐ Male ☐ Female Is this person a ☐ migrant or ☐ seasonal farmworker? ☐ Yes ☐ No

Marital Status **Race (optional)** **What kind of help does this person need?**

☐ Married ☐ White (non-hispanic) ☐ Food
☐ Never Married ☐ Black ☐ Medical
☐ Divorced ☐ Asian/Pacific Islander ☐ Child Care
☐ Separated ☐ Hispanic ☐ Cash for Families or Disabled Adults
☐ Widowed ☐ American Indian/Alaska Native ☐ State Emergency Relief
What Tribe? _____ ☐ None

Highest grade finished in school _____

Is Person 5 in school? (school, college or university) ☐ Yes ☐ No

If yes, ▶ Name of School _____ ☐ Full Time ☐ Part Time

Answer if Person 5 Wants Help

U.S. Citizen? ☐ Yes ☐ No Social Security Number _____ * Optional if applying ONLY for child care or emergency medical services.



B. Expedited Food Assistance (7-Day Processing)

1. Does everyone in the household buy food, fix or eat meals together? ☐ Yes ☐ No
If no, who does not? _____
2. How much is the total gross income (before taxes) for your household?
(Include earnings, unemployment benefits, child support, Social Security benefits, etc.) \$ _____
3. How much are the total cash assets belonging to your household?
(Include cash, savings, checking, saving bonds, etc.) \$ _____
4. Does anyone in your household receive Tribal Food Distribution benefits? ☐ Yes ☐ No
If yes, who? _____

C. Household Information

1. **Check where you live:** ☐ House/apartment/mobile home ☐ Homeless ☐ Other _____
If you live in a facility, check what type::

<input type="checkbox"/> Assisted living	<input type="checkbox"/> Hospital	<input type="checkbox"/> Jail/prison	<input type="checkbox"/> Juvenile Residential Facility
<input type="checkbox"/> Home for the aged	<input type="checkbox"/> County infirmary	<input type="checkbox"/> Emergency housing/shelter	<input type="checkbox"/> Community Justice Center
<input type="checkbox"/> Group home	<input type="checkbox"/> Nursing facility	<input type="checkbox"/> Domestic violence shelter	
<input type="checkbox"/> Adult foster care home	<input type="checkbox"/> Mental health or psychiatric facility		
<input type="checkbox"/> Commercial boarding house	<input type="checkbox"/> Drug or alcohol treatment center		

Expected Date of Release from Facility
____/____/____ ☐ **Date Unknown**
2. _____
Home address (number, street, rural route, apartment / lot number)

City State Zip code County
3. _____
Mailing address (if different from home address)

City State Zip code County
4. _____
Home phone Work phone Cell phone

TTD or TTY number

Phone number where we can leave a message Whose number is it? (name / relationship)

Email address

Number, street or PO box City State Zip code

C. Household Information (continued)



8. Have you received benefits from another state since August 1996? ☐ Yes ☐ No

If yes, what state? _____ What county? _____

____/____/____

Date you moved here

Caseworker name

____-____-____

Caseworker phone number

9. Has anyone in the household applied for or received benefits from Michigan? ☐ Yes ☐ No

▶ If yes, do you have a Bridge Card?

☐ Yes ☐ No

For more information about these cards
see the **Information Booklet**.

▶ If yes, do you have your mihealth card(s)?

☐ Yes ☐ No

Who needs a mihealth card? _____

10. If you are eligible for Food Assistance, do you want someone else to shop for you? ☐ Yes ☐ No

If yes, enter his/her full name _____

(This is your authorized representative.)

D. Answer for Household Members Under 22



NOTE: Ask for Additional Household Members Under 22 pages if needed.

Person(s) under 22	Parent's full name	Check if parent is deceased.	If there is joint custody, how many days per month does the child stay with each parent?	Check box(es) below if: • parents were ever married to each other • paternity was legally established • support is court ordered
	Mother	<input type="checkbox"/> Yes		<input type="checkbox"/> Married <input type="checkbox"/> Paternity <input type="checkbox"/> Support Order # _____
	Father	<input type="checkbox"/> Yes		
	Mother	<input type="checkbox"/> Yes		<input type="checkbox"/> Married <input type="checkbox"/> Paternity <input type="checkbox"/> Support Order # _____
	Father	<input type="checkbox"/> Yes		
	Mother	<input type="checkbox"/> Yes		<input type="checkbox"/> Married <input type="checkbox"/> Paternity <input type="checkbox"/> Support Order # _____
	Father	<input type="checkbox"/> Yes		
	Mother	<input type="checkbox"/> Yes		<input type="checkbox"/> Married <input type="checkbox"/> Paternity <input type="checkbox"/> Support Order # _____
	Father	<input type="checkbox"/> Yes		



E. Employment income

NOTE: Ask for more Employment Income pages if needed.

1. Is anyone in your household self-employed or will anyone be self-employed before the end of the next calendar month? ☐ Yes ▶ **Complete the table** ☐ No

Self-employed person(s)	Type of work or business	Business name and address	Gross monthly income (amount before any deductions or expenses)	Monthly self-employment expenses

2. Is anyone in your household working for wages or salary or will anyone begin working before the end of the next calendar month? ☐ Yes ▶ **Complete the information for each person working** ☐ No

Name of **1st** person working _____ Start date ____/____/____

Employer name and address _____

If new job, first check date ____/____/____

Will employment continue? ☐ Yes ☐ No

Number of hours expected to work _____ per

☐ Week

Rate of

☐ Hourly

☐ Pay Period

pay \$ _____

☐ Salary

☐ Other _____

Do you receive tips, bonus or commission not included in your check? ☐ Yes ☐ No

☐ **Tips:** Amount not included in your check \$ _____ per ☐ Hour ☐ Week ☐ Other

☐ **Bonus/Commission:** Amount you receive \$ _____ How often? _____

How often paid: ☐ Weekly ☐ Every other week ☐ Twice a month ☐ Monthly ☐ Other _____

Day of week paycheck received _____ Date last pay received ____/____/____

Name of **2nd** person working _____ Start date ____/____/____

Employer name and address _____

If new job, first check date ____/____/____

Will employment continue? ☐ Yes ☐ No

Number of hours expected to work _____ per

☐ Week

Rate of

☐ Hourly

☐ Pay Period

pay \$ _____

☐ Salary

☐ Other _____

Do you receive tips, bonus or commission not included in your check? ☐ Yes ☐ No

☐ **Tips:** Amount not included in your check \$ _____ per ☐ Hour ☐ Week ☐ Other

☐ **Bonus/Commission:** Amount you receive \$ _____ How often? _____

How often paid: ☐ Weekly ☐ Every other week ☐ Twice a month ☐ Monthly ☐ Other _____

Day of week paycheck received _____ Date last pay received ____/____/____

F. Migrant or Seasonal Farmworker Income



Is anyone in your household a ☐ migrant or ☐ seasonal farmworker?

☐ Yes ▶ Check the box(es) that apply and complete the table ☐ No

Check all that apply	Name of Person(s)	Date	Gross amount
<input type="checkbox"/> Already received income this month			
<input type="checkbox"/> Expects to receive more income this month			
<input type="checkbox"/> Received a travel advance			
<input type="checkbox"/> Recently lost only source of income		Last check date	Gross amount

G. Employment Changes - Past 30 Days



Did anyone in your household have changes in employment in the last 30 days?

☐ Yes ▶ Check the box(es) that apply and complete the table ☐ No

Check all that apply	Name of person(s)	Name and Address of Employer	Date of change	Date and Gross amount of final check
<input type="checkbox"/> Refused work Reason_____				
<input type="checkbox"/> Voluntarily reduced hours worked Reason_____				
<input type="checkbox"/> Quit a job Reason_____				
<input type="checkbox"/> Was laid off Reason_____				
<input type="checkbox"/> Was fired Reason_____				
<input type="checkbox"/> Is participating in a strike Reason_____				

H. Household Disclosure



Has, or Is, anyone in your household:	Person(s)	No One
• ever been disqualified or had their benefits reduced or stopped for breaking the rules of a program such as Food or Cash Assistance?		<input type="checkbox"/>
• ever been convicted of fraud for receiving cash or food assistance from two or more states at the same time?		<input type="checkbox"/>
• fleeing from felony prosecution or jail?		<input type="checkbox"/>
• been convicted of a drug related felony occurring after August 22, 1996?		<input type="checkbox"/>
• in violation of probation or parole?		<input type="checkbox"/>



I. Other Income

1. Does anyone in your household receive any other income?

☐ Yes ▶ Check all other income that your household receives and complete the table ☐ No

- | | | |
|--|--|---|
| <input type="checkbox"/> Social Security benefits | <input type="checkbox"/> Supplemental Security Income (SSI) | <input type="checkbox"/> Disability benefits |
| <input type="checkbox"/> Pension / retirement benefits | <input type="checkbox"/> Workers compensation | <input type="checkbox"/> Unemployment compensation |
| <input type="checkbox"/> Veterans benefits | <input type="checkbox"/> Money from friends or relatives, etc. | <input type="checkbox"/> Rental income |
| <input type="checkbox"/> Military allotments | <input type="checkbox"/> Child support | <input type="checkbox"/> Interest / dividend income |
| <input type="checkbox"/> Land contract, mortgage or other notes payable to a household member | <input type="checkbox"/> Other _____ | |
| <input type="checkbox"/> Income / payments from a tribe (tribal GA, land claims, casino profit sharing, per capita, etc.) | | |

Person(s) receiving money	Income source / type	How often received	Amount received	Expected to continue
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No

2. Check if anyone in your household is a: ☐ Disabled U. S. veteran ☐ Spouse, child or parent of a disabled U. S. veteran
☐ Widow(er), child or parent of a deceased U. S. veteran ☐ No one

Who? _____

E

J. Child Care

NOTE: Ask for Additional Child Care pages if needed.

1. Do you need help paying for child care? ☐ Yes ▶ Check the reason(s) why and complete both tables. ☐ No

- ☐ Work ☐ High school or GED ☐ Education / training approved by DHS or Michigan Works! Agency
☐ Emotional/health or social problem (explain): _____

2. Enter the days and times of the parent(s)/substitute parent(s) schedule for the reason checked above.

Parent's Name	Reason	Mon. Times	Tues. Times	Wed. Times	Thurs. Times	Fri. Times	Sat. Times	Sun. Times

Child(ren)'s name(s)	Is provider related to child? Yes or No	How?	Provider name, address and phone number	Provider ID number	Care provided in child's home	Date care began
					<input type="checkbox"/> Yes <input type="checkbox"/> No	
					<input type="checkbox"/> Yes <input type="checkbox"/> No	
					<input type="checkbox"/> Yes <input type="checkbox"/> No	

K. Disability Benefits



1. If not already receiving disability benefits, has anyone in your household applied for or been denied benefits? ☐ Yes ☐ No **▶ Check all disability benefits that apply and complete the table**

Person(s)	Type of benefit	Benefit Status	Status Date (if known)
	<input type="checkbox"/> Social Security benefits <input type="checkbox"/> Supplemental Security Income (SSI) <input type="checkbox"/> Other _____	<input type="checkbox"/> Applied for benefits <input type="checkbox"/> Denied benefits * <input type="checkbox"/> Appealed the denial <input type="checkbox"/> Requested a hearing	
	<input type="checkbox"/> Social Security benefits <input type="checkbox"/> Supplemental Security Income (SSI) <input type="checkbox"/> Other _____	<input type="checkbox"/> Applied for benefits <input type="checkbox"/> Denied benefits * <input type="checkbox"/> Appealed the denial <input type="checkbox"/> Requested a hearing	
	<input type="checkbox"/> Social Security benefits <input type="checkbox"/> Supplemental Security Income (SSI) <input type="checkbox"/> Other _____	<input type="checkbox"/> Applied for benefits <input type="checkbox"/> Denied benefits * <input type="checkbox"/> Appealed the denial <input type="checkbox"/> Requested a hearing	
	<input type="checkbox"/> Social Security benefits <input type="checkbox"/> Supplemental Security Income (SSI) <input type="checkbox"/> Other _____	<input type="checkbox"/> Applied for benefits <input type="checkbox"/> Denied benefits * <input type="checkbox"/> Appealed the denial <input type="checkbox"/> Requested a hearing	

* Social Security Administration has decided he/she is not disabled.

2. If benefits were denied, have the health problem(s) of anyone changed?

Who _____ Date of Change _____

☐ Health Problem is Worse
 ☐ New Health Problem
 ☐ More Than One Health Problem Now

L. Medical Coverage



Does anyone in your household have, or expect to have, medical coverage (other than Medicaid)? ☐ Yes ☐ No **▶ Check which type of coverage and complete the table**

☐ Health/hospital insurance (employer, parent, etc.)
 ☐ Accident (home or car insurance, etc.)
 ☐ Workers compensation
☐ Medicare
 ☐ MICHild
 ☐ Plan/contract (life care contract, etc.)
 ☐ Other _____

Person(s) covered	Name and address of insurance company	Claim, contract/group number(s)



M. Medical Information

1. List anyone who is **pregnant now** or was **pregnant in the past 3 months**: ☐ No one is pregnant.
- | 1st Pregnant Person | Due date/
delivery date | How many
babies expected | 2nd Pregnant Person | Due date /
delivery date | How many
babies expected |
|---------------------|----------------------------|-----------------------------|---------------------|-----------------------------|-----------------------------|
| | | | | | |
2. List any children under 6 years of age who are **not** up to date on their immunizations (shots) ☐ None
3. List any children in an *Early On*® Program ☐ None
Name and phone number of *Early On* Coordinator _____
4. List anyone who is now/has ever been in a special education class ☐ None
Name and phone number of school _____
5. List anyone going to an alcohol or drug treatment program ☐ None
6. List anyone working with Michigan Rehabilitation Services ☐ None
Name and phone number of Michigan Rehabilitation counselor _____
7. If anyone in your household is ☐ Blind ☐ Disabled ☐ Caring for disabled child or spouse, complete the table:
- | Person(s) | Medical Condition | Check if: |
|-----------|-------------------|---|
| | | <input type="checkbox"/> Unable to work |
| | | <input type="checkbox"/> Unable to work |
| | | <input type="checkbox"/> Unable to work |



N. Medical Information and Expenses

1. List any person with paid or unpaid medical expenses for services provided in the last 3 months:
▶ Who? _____ What months? _____
2. Does anyone in your household have any ongoing medical expenses?
☐ Yes ▶ Check all expenses that apply and complete the table ☐ No
- | | | |
|---|--|--|
| <input type="checkbox"/> Medical care | <input type="checkbox"/> Prescribed over-the-counter drugs | <input type="checkbox"/> Seeing eye / hearing dog |
| <input type="checkbox"/> Dental care | <input type="checkbox"/> Prescription drugs | <input type="checkbox"/> Guardian / conservator fees |
| <input type="checkbox"/> Hospitalization | <input type="checkbox"/> Prescription drug discount card | <input type="checkbox"/> Health insurance premium |
| <input type="checkbox"/> Transportation for medical care
(for pregnancy or ongoing care) | <input type="checkbox"/> Dentures | <input type="checkbox"/> Medicare premium |
| <input type="checkbox"/> Emergency room | <input type="checkbox"/> Eyeglasses | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Nursing facility care | <input type="checkbox"/> Hearing aids | |
| | <input type="checkbox"/> Prosthetics | |
- | Person(s)
with expense(s) | Medical expense(s)
(checked above) | Amount
you pay | How often (monthly,
yearly, etc.) |
|------------------------------|---------------------------------------|-------------------|--------------------------------------|
| | | | |
| | | | |
| | | | |
| | | | |
3. ☐ I would like more information about the AMP employer sponsored insurance option.
For more information about this option see the *Information Booklet*.

O. Asset Information (Include Assets Held Jointly)



1. Does anyone in your household have any assets?

☐ Yes **▶ Check all types of assets your household has and complete the table** ☐ No

- | | | |
|---|---|---|
| <input type="checkbox"/> Checking/draft accounts | <input type="checkbox"/> Money market accounts | <input type="checkbox"/> Savings/share accounts |
| <input type="checkbox"/> Certificates of Deposit (CD) | <input type="checkbox"/> Christmas club accounts | <input type="checkbox"/> Patient trust fund |
| <input type="checkbox"/> Cash on hand or in safe deposit | <input type="checkbox"/> Savings bonds, stocks or mutual funds | <input type="checkbox"/> IRA, KEOGH, 401K or Deferred Compensation account(s) |
| <input type="checkbox"/> Trust or annuities | <input type="checkbox"/> Land contract, mortgage or other notes payable to household member | <input type="checkbox"/> Real estate (not including place you live) |
| <input type="checkbox"/> Life estate | <input type="checkbox"/> Burial plot(s), casket, etc. | <input type="checkbox"/> Tools and equipment, livestock or crops |
| <input type="checkbox"/> Life insurance | <input type="checkbox"/> Other Assets _____ | |
| <input type="checkbox"/> Burial Trust/funeral contract(s) | | |

Owner(s) of asset(s)	Type(s) of asset(s)	Balance, amount or value	Name and address (bank, insurance company, etc.)	Account/ policy number, etc.

2. Does anyone in your household have any vehicles?

☐ Yes **▶ Check all vehicles that apply and complete the table** ☐ No

- ☐ Car ☐ Truck ☐ Boat ☐ Campers / trailers ☐ Motorcycles ☐ RV ☐ Other vehicles

Owner(s) (As shown on vehicle title or registration)	Year	Make / Model	Amount owed

3. Has anyone in your household:

- | | |
|--|---|
| • sold or given away property, land, vehicles, stocks, bonds, savings, cash, checking, income, etc., closed any accounts or removed or added a name on any asset within 60 months? | <input type="checkbox"/> Yes ▶ Who:
<input type="checkbox"/> No |
| • filed a pending lawsuit which may bring money, property, etc.? | <input type="checkbox"/> Yes ▶ Who:
<input type="checkbox"/> No |
| • received a one-time cash payment (such as worker's compensation, lottery winnings, insurance settlement, lawsuit award, etc.) within the last 60 months? | <input type="checkbox"/> Yes ▶ Who:
<input type="checkbox"/> No |
| • or has anyone acting for any household member, ever put any money, lawsuit settlement, income or assets in a trust, annuity or similar legal device? | <input type="checkbox"/> Yes ▶ Who:
<input type="checkbox"/> No |



P. Shelter Expenses

Check the boxes that apply and fill in the amount. *If you are applying for MEDICAL ASSISTANCE ONLY you can skip this section (unless you will be in a nursing home and have a spouse or dependent at home).

1. ☐ Rent \$ _____ (enter only the amount **you** pay, NOT amount paid by HUD, Section 8, MSHDA, etc.)
☐ Renter's Insurance \$ _____ per year (for nursing home help if spouse or dependent at home)
2. Does anyone pay for:
Rent that includes meals (room and board) ☐ Yes ▶ \$ _____ per month ☐ No
Meals only (board) ☐ Yes ▶ \$ _____ per month ☐ No
3. ☐ Mobile home lot rent \$ _____ per month
4. ☐ Mortgage/Mobile Home/Land contract \$ _____ per month
5. ☐ Second mortgage or home equity loan \$ _____ per month
6. Shelter expenses **separate** from rent or mortgage:
☐ Heat (gas, electric, propane, wood, etc.) ☐ Homeowner's insurance \$ _____ per year
☐ Electricity (non-heat) ☐ Property taxes \$ _____ per year
☐ Water/Sewer ☐ Special assessments \$ _____ per _____
☐ Cooking fuel ☐ Mortgage guarantee insurance \$ _____ per _____
☐ Garbage/Trash pick-up ☐ Cooperative/Condominium/Association fee \$ _____
☐ Telephone ☐ Other _____ \$ _____

7. Michigan Department of Treasury Home Heating Credit (HHC)

- a. Has anyone in your household received a HHC for the **current address**? ☐ Yes ☐ No
- b. Will anyone in your household apply for, or does anyone expect to apply for the HHC for the **current address**? ☐ Yes ☐ No
- c. Does the landlord live in the home? ☐ Yes ☐ No



Q. Court Ordered Support and Dependent Care Expenses

1. Does anyone in your household pay ☐ court-ordered child support ☐ spousal support?
☐ Yes ▶ Check which one above and complete the table below ☐ No

Person(s) paying	Court order number	Order amount	Amount paid	For whom
			\$ _____ <input type="checkbox"/> Week <input type="checkbox"/> Month	
			\$ _____ <input type="checkbox"/> Week <input type="checkbox"/> Month	
			\$ _____ <input type="checkbox"/> Week <input type="checkbox"/> Month	

2. Does anyone pay for care of a child or a disabled family member?

- ☐ Yes ▶ Complete the table (DO NOT include amounts paid by DHS or anyone else) ☐ No

Person(s) paying	Amount paid	For whom
	\$ _____ <input type="checkbox"/> Week <input type="checkbox"/> Month	
	\$ _____ <input type="checkbox"/> Week <input type="checkbox"/> Month	
	\$ _____ <input type="checkbox"/> Week <input type="checkbox"/> Month	

Representative, Guardian, Conservator or Person Helping With Application

If you are filling this application out for someone else, or representing the person applying, complete the following information:

Name and Title

____-____-____
Phone Number

Street Address (Number, Street, Rural Route, Apt. Number, Lot Number)

City

State

Zip Code

Representative's Relationship to Applicant

If you are under age 18, are you married? ☐ Yes ☐ No

Affidavit

IMPORTANT: You must sign the application after reading the Affidavit.

Under penalties of perjury, I swear that this application has been examined by or read to me, and, to the best of my knowledge, the facts are true and complete. If I am a third party applying on behalf of another person, I swear that this application has been examined by or read to the applicant, and, to the best of my knowledge, the facts are true and complete.

I certify that I have received a copy, reviewed and agree with the sections in the **Assistance Application Information Booklet** explaining how to apply for and receive help, Programs Offered by DHS, Things I Must Do, Important Things to Know, Penalties for Fraud or Intentional Program Violation, If I Receive Tribal Benefits, Benefits I Must Give DHS as Repayment, If I Receive Support Payments and Information About My Household That Will Be Shared.

I certify, under penalty of perjury, that all the information I have written on this form or told my DHS worker or my representative is true. I understand I can be prosecuted for perjury if I have intentionally given false or misleading information, misrepresented, hidden or withheld facts which caused me to receive assistance I should not have received or more assistance than I should have received. I can be prosecuted for fraud and/or required to repay the amount wrongfully received. I understand I may be asked to show proof of any information I have given.

Signature of client or representative

Date

Signature of agency witness (when in-person interview completed)

Load #

Date

Notes

This image shows a single page from a notebook or ledger. The page is white with rounded corners at the top and bottom. It features horizontal blue ruling lines spaced evenly apart. There are no vertical margin lines, and the page is completely blank except for the lines.

Notes

SER Eligibility Certification - Office Use Only

[illegible]

Case Eligibility Certification - Office Use Only

<input type="checkbox"/> Voter Registration action taken <input type="checkbox"/> Application <input type="checkbox"/> Redetermination <input type="checkbox"/> Other <input type="checkbox"/> Reinstatement <input type="checkbox"/> Member Add				New Application Date		Updated Application Date	
Program	Approved	Spend-Down	Denial Code	Date	Signature	Load No.	
FIP	<input type="checkbox"/> Yes						
SDA	<input type="checkbox"/> Yes						
AMP	<input type="checkbox"/> Yes						
FAP	<input type="checkbox"/> Yes						
EXP FAP	<input type="checkbox"/> Yes						
A MA Month:	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes					
B MA Month:	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes					
C MA Month:	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes					
D MA Month:	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes					
E MA Month:	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes					
CDC	<input type="checkbox"/> Yes						
Other	<input type="checkbox"/> Yes						

Transfer Out				Closure			
New address (street no. and name)				Enter Appropriate Negative Action Code			
City		State	Zip code	<input type="checkbox"/> FIP _____ <input type="checkbox"/> FAP _____ <input type="checkbox"/> CDC <input type="checkbox"/> SDA _____ <input type="checkbox"/> MA _____ <input type="checkbox"/> AMP _____ <input type="checkbox"/> Other _____ <input type="checkbox"/> Budget completed (Excess income/assets) <input type="checkbox"/> Eligibility for other programs explored			
Phone		County/District					
Date of move	Date notified	Household composition change <input type="checkbox"/> Yes <input type="checkbox"/> No					
Other <input type="checkbox"/> Third Party Payee change <input type="checkbox"/> Pending case action(s) <input type="checkbox"/> FAP benefit period changed - Reason:				<input type="checkbox"/> Closure deleted on Date _____ Because the Client:			
Notices given: <input type="checkbox"/> Client <input type="checkbox"/> Support Specialist <input type="checkbox"/> Work First <input type="checkbox"/> Services		<input type="checkbox"/> Accounting/Fiscal units <input type="checkbox"/> Child care provider <input type="checkbox"/> OIG <input type="checkbox"/> Administrative Hearings <input type="checkbox"/> Other		<input type="checkbox"/> Requested Administration Hearing _____ <input type="checkbox"/> Claimed different impairment... _____ <input type="checkbox"/> Claimed additional impairment _____ <input type="checkbox"/> Claimed impairment worsened _____ <input type="checkbox"/> Other _____			
Notes				Notices given: <input type="checkbox"/> Child care provider <input type="checkbox"/> Client <input type="checkbox"/> Accounting/Fiscal units <input type="checkbox"/> Support Specialist <input type="checkbox"/> OIG <input type="checkbox"/> Work First <input type="checkbox"/> Administrative Hearings <input type="checkbox"/> Services <input type="checkbox"/> Other			
Signature				Signature			
Load number		Date		Load number		Date	